DETERMINATION OF MEDICAID DISABILITY SOCIAL SUMMARY FOR PROGRESS REPORT

State Form 51725 (5-04) / OMPP 0251PR

ALL 6 Sections Must Be Completed.

CONFIDENTIALITY STATEMENT

The personal information requested on this form will be used in the determination of the applicant's entitlement to or continued receipt of Medical Assistance administered by the Office of Medicaid Policy and Planning. Disclosure by the applicant of the information requested is mandatory pursuant to the provisions of IC 12-15 et seq. Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance to the applicant. All personal information collected on this form will be treated as confidential pursuant to 470 IAC 1-2-7 and 470 IAC 1-3-1.

Who completed this form?

☐ Caseworker ☐ Other (*explain relationship to recipient*): _____

How was the interview conducted?

☐ In person ☐ By telephone ☐ Information was taken by a professional service.

SECTION 1. IDENTIFYING INFORMATION

Name of recipient		Social Security number
Case number	RID number	Date of birth (*month, day, year*)

SECTION 2. SOCIAL SECURITY INFORMATION

During the time period of this progress report, did the recipient apply for:

(a) Social Security Disability benefits? ☐ Yes ☐ No

(b) Supplemental Security Income (SSI) benefits? ☐ Yes ☐ No

If yes to (a) or (b) above, was the application approved or denied?

Effective date of denial: _____

Effective date of approval: _____

Application is pending: _____

SECTION 3. LIVING ARRANGEMENTS

During the time period of this progress report, did the recipient's living arrangements change? If yes, please explain:

☐ Yes ☐ No

SECTION 4. EDUCATION AND WORK

Did the recipient obtain additional education during the progress report period? If yes, please explain:

☐ Yes ☐ No

Was the recipient employed during the progress report period?

☐ Yes ☐ No

If yes: (a) Number hours worked per week	(b) Title or position held
(c) Salary: $ _____ per hour **or** $ _____ per week.	(d) Still working presently? ☐ Yes ☐ No
If no, date last worked:	

SECTION 5. MEDICAL HISTORY

Recipient states (s)he has the following NEW physical and / or mental disability	Date Disability Began

Medical and Psychological Treatment History <u>During the Progress Report Period:</u>
(***Fill in or write the word "NONE." This table cannot be left blank!***)

Full Name and Address of Doctor, Psychiatrist, Hospital, Clinic, Institution, Mental Health Agency or Other	Date of Most Recent Care	Reason for Visit

Recipient is taking the following ***medications*** (*correct spelling and dosage is important*) **/ *treatments* / *therapies*:**

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

SECTION 6. CASEWORKER'S SUMMARY (** *Very important to complete.* **)

(a) **Appearance**: (*Describe what you see.*)

(b) **Medical**: (*Describe what you see and hear relating to the recipient's disability.*)

(c) **Social**: (*Describe how the recipient behaves during the interview. Is (s)he able to understand your questions? Is (s)he able to communicate with you in an understandable manner?*)

(d) **Other**: